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Remarks by Dempsey Benton
Secretary
North Carolina Department of Health & Human Services
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On behalf of the Department of Health and Human Services and myself personally, we deeply regret that Mr. Sabock died and that it occurred while a patient at Cherry Hospital.
The Department finds the circumstances related to this tragic death at Cherry Hospital completely unacceptable. The Department is dedicated to providing quality care to consumers in the state facilities and the substandard care that was evident in this case will not be tolerated.

The following corrective actions are being taken:

The 23 bed ward on which this tragic circumstance occurred has been ordered to be closed as of today. There are 16 staff who should have been more responsive to Mr. Sabock's needs while a patient at Cherry. They will be removed from direct care duties and given other assignments for at least 60 days. They will be required to receive additional training and re-education during this time to assure they understand our expectations and are prepared to provide quality care. If and when they are deemed ready by the Hospital Director, they will be returned to direct care but under a training supervisor. The shifts on which they perform their duties will be as determined by the Hospital Director.

Not all the staff on the ward were involved. These staff will be reassigned to the three remaining wards to improve staffing supervision and quality of care.

Closing of one ward reduces the Adult Admission section from 90 beds to 67. Reassignment of the staff not involved allows the hospital to have two registered nurses on all three shifts. This will increase the supervision of staff from the previous arrangements which often operated with one nurse on a shift.

Having two nurses on each shift in the Adult Admissions Unit will be a staffing standard for the future at Cherry Hospital. Hospital Management is directed to evaluate the staffing situation on the Adult Admissions Unit over the next 60 days to determine if staffing levels are adequate for the 67 beds and whether all or part of the 23 bed ward capacity can be reactivated with the two nurse requirement.

Following the death, hospital management took disciplinary action that affected these 16 staff. These actions ranged from counseling to up to five day suspensions and one departure during the investigation. This level of disciplinary action is insufficient. Hospital Management is being directed to re-examine the disciplinary actions.

The Hospital Director has been notified of the requirement going forward that the importance of quality care demands a more rigorous disciplinary protocol than has been applied in the past. This is especially applicable at the time when a patient has been mistreated or provided inadequate care. Such personnel actions must be more consistent with this expectation of service and stewardship and the severity of the problem to be corrected.

The Division of Mental Heath is taking steps to require more timely reporting to Division Management from advocate staff in the hospital when significant care problems are identified. These actions will be parallel to and independent of the reporting requirements of Hospital Management to Division Management.

The Division will provide on-going external management oversight for the next 90 days. This will involve six professionals who will closely monitor document quality in the wards, participate in assuring increased quality of supervision and nursing care for patients, as well as increased staff training on treatment protocols. The team will include a physician consultant.

At the Hospital Management level, the Director has been working hard to improve overall quality of care. During the past year, the frequency of use of restraint and seclusion procedures has been greatly reduced by use of less confrontational treatment.

Video recording devices have been installed throughout the hospital in the past year as part of this effort to enhance awareness of patient care conditions. The level of knowledge about this incident is in part a result of this effort.

While he has been working to address some long standing service issues, the assessment of the efforts surrounding this patient's death leads to the conclusion that a more aggressive correction and adjustment effort should have been pursued including review and evaluation with the department management. This will be addressed by Division Management in their evaluation of his handling of this case.

The efforts of the hospital management team in the post event follow up evaluation and level of corrective actions undertaken should have been more vigorously pursued by the Standards Manager. The standards manager is responsible for leading the hospital's internal analysis of patient incidents and developing corrective action plans. These functions will be assigned to other staff as approved by the Hospital Director and Division Management. The director will undertake an evaluation of the performance of this individual.

From a hospital operations perspective, these actions reduce the capacity of Cherry Hospital from 274 beds to 251 beds overall and from 90 beds to 67 beds in the Adult Admissions Unit. In the past, the hospital has periodically exceeded these levels by 10% due to demands for services.

Going forward, I have directed that the new capacity levels not be exceeded. The Division Management will undertake an assessment of the level of bed capacity which can be provided with the staffing authorized for this hospital, including the level of operations oversight in the wards necessary for quality of service assurance.

This report will be completed within the next 60 days. The staff will consult with and review the study with the Local Management entities in the Cherry Hospital Service Area. These local and regional agencies are a key partner in the effort to provide services, and are responsible for the initial review of an individual's treatment needs and referral to the hospital or other treatment facilities in the region.

The reduction in adult admission beds will have an impact on the level of service the hospital can provide in the eastern area of the state.

During the Legislation session, the administration requested funding to secure 180 beds in community hospitals across the state to enhance the frequency where consumers could receive initial treatment near their homes rather than at the state hospitals. Funding for 75 beds was approved by the Legislators and the department will be actively pursuing contracts with community hospitals to operationalize these beds. Approximately 25 will be in the Eastern Region which will moderate the service level impact of these hospital adjustments.